

EMERGENCY MEDICAL TREATMENT CONDITIONS OF ADMISSION

PART II

FINANCIAL AGREEMENT: I understand and agree that I am the person responsible for paying the Hospital/Clinic if the patient does not have insurance, at the regular rates and terms of the Hospital/Clinic. If I do not pay and the bill goes to collections, I agree to pay any attorney’s fees and collection expenses. If my account is late, I agree that I can be charged interest at the legal rate.

MEDI-CAL/MEDICARE: If I filled out Medi-Cal or Medicare Program forms, I agree that I filled out the forms truthfully. I agree to release information needed to complete this request. I agree to allow payment to be made directly to the County of Los Angeles Department of Health Services. I agree to pay any leftover charges that I am legally responsible for. I give the rights that I have to payment under Medicare Part A or B for care at Hospital/Clinic, including any physician services to Hospital/Clinic.

ASSIGNMENT OF INSURANCE BENEFITS: I agree to allow patient’s insurance company to pay the County of Los Angeles directly. This includes Medical Groups associated with the County. I agree to pay any leftover charges not paid by the insurance company. I agree to pay for services provided to the patient and accept the terms above.

WITNESS SIGNATURE	PATIENT OR RESPONSIBLE PERSON SIGNATURE	RELATIONSHIP TO PATIENT	DATE	TIME
ADDRESS	STREET	CITY	ZIP	

MRUN

NAME

DOB/GENDER

